BOARD OF DIRECTORS

CALL TO ORDER

ADOPTION OF MINUTES

July 16th, 2015

CHIEF MEDICAL OFFICER REPORT

DR. WILSON

CHIEF INFORMATION OFFICER REPORT

MR. GUIDO

ACTION ITEM:

I. Authorizing the New York City Health and Hospitals Corporation (HHC), through its President, to delegate to each acute care hospital’s Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through each hospital’s Quality Assurance process to the Board of Directors.

II. Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to enter into a sole source agreement with SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed $4,769,555 (which includes a contingency reserve of $229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms.
INFORMATION ITEM:

I. MetroPlus Annual Report
   DR. SAPERSTEIN

II. Patient Safety
    MS. JACOBS/
    MS. KONG

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT
MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: July 16, 2015

ATTENDEES

COMMITTEE MEMBERS
Vincent Calamia, MD, Committee Chair
Josephine Bolus, RN
Antonio Martin, (representing Dr. Ram Raju in voting capacity)
Hillary Kunins, MD (representing Dr. Gary Belkin in a voting capacity)

HHC CENTRAL OFFICE STAFF:
Machelle Allen, MD, Deputy Chief Medical Officer, Office of Health Care Improvement
Chalice Averett, Director, Office Audit Internal
Charles Barron, MD, Director of Psychiatry, Office of Behavioral Health
Janette Baxter, Senior Director, Risk Management
Donna Benjamin, Restructuring Project Management Officer
Nicholas Cagliuso, Sr., PhD, MPH, Assistant Vice President, Emergency Management
Deborah Cates, Chief of Staff, Board Affairs
Tammy Carlisle, Associate Executive Director, Corporate Planning
Megan Cunningham, Director, Accountable Care Organization
Carolyn Dunn, Senior Director, Marketing
Kenra Ford, Assistant Vice President Clinical Lab Operations/M&PA
Juliet Gaengan, Senior Director, Quality and Innovation
Alfred Garofalo, Senior Director, Enterprise Information Technology System
Sal Guido, Acting Chief Information Officer, Enterprise Information Technology System
Terry Hamilton, Assistant Vice President, Corporate Planning
Christina Jenkins, MD, Chief Executive Officer, OneCity Health
Lauren Johnston, Senior Assistant Vice President, Office of Patient Centered Care
John Jurenko, Senior Assistant Vice President, Intergovernmental Relations
Susan Kansagra, Assistant Vice President, Population Health
Barbara Keller, Deputy Counsel, Legal Affairs
Barbara Lederman, Senior Director, Enterprise Information Technology System
Patricia Lockhart, Secretary to the Corporation
Ana Marengo, Senior Vice President, Communications & Marketing
Randall Mark, Chief of Staff, President Office
Ian Michaels, Media Director, Communication and Marketing
Deirdre Newton, Senior Counsel, Legal Affairs
Darren Ng, Systems Analyst, Corporate Budget
Charlotte Nuehaus, Senior Management Consultant, Corporate Planning Services
Christopher Philippou, Assistant Director, Corporate Planning
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Lynnette Sainbert, Assistant Director, Board Affairs
Marisa Salamone Gleason, Assistant Vice President, Enterprise Information Technology System
Eli Tarlow, Enterprise Information Technology System
FACILITY STAFF:
Lillian Diaz, Chief Nurse Executive, Metropolitan Hospital Center
Seth Diamond, Chief Operating Officer, MetroPlus Health Plan, Inc.
John Maese, MD, Medical Director, Coney Island Hospital
Andreea Mera, Special Assistant to the President, MetroPlus Health Plan, Inc.
John T. Pellicone, Chief Medical Officer, Metropolitan Hospital Center
Denise Soares, Senior Vice President, Generation + Network

OTHERS PRESENT:
James Cassidy, Office of Management and Budget
Kent Cherny, Office of Management and Budget
Tyler DeRubis, Analyst, Office of Management and Budget
Mark Heron, Assistant Director, Director DC37
Scott Hill, Account Executive Quadramed
David N. Hoffman, Chief Compliance Officer, PAGNY
Kristyn Raffaele, Analyst, Office of Management and Budget
MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, July 16, 2015

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:00 AM. The minutes of the June 11th, 2015 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT

Machelle Allen, MD, Deputy Chief Medical Officer, reported on the following initiatives.

Office of Population Health

This summer, HHC will be participating in another season of the Fruit and Vegetable Prescription program in partnership with Wholesome Wave. The program supports overweight or obese children and their families with nutrition education and goal-setting on healthy eating. The program also provides families with a prescription for fruits and vegetables that can be redeemed for fresh produce at local farmers’ markets.

Office of Behavioral Health

1. Transformation Project; Readiness for Managed Care:
   A learning session was held on June 23, 2015 which presented the results of the four pilot sites and presented the next step pilots for all HHC facilities. The conference was well attended and included several CEO’s and CFO’s of the facilities demonstrating the commitment of facility leadership to this process. Evaluation of the conference was very positive and attendees demonstrated high levels of enthusiasm and energy about the projects. The pilots that are planned for all facilities are the following:
   - Increase Behavioral Health Access: by expansion of the current Access project;
   - High Utilizer Data project: focusing on high utilizers of psychiatric emergency room services;
   - Inpatient to Outpatient Bridging: using peers for transition;
   - Outpatient Engagement: using community outreach to engage patients;
   - Behavioral Health, Primary Care Integration: transition of identified stable patients from Behavioral Health clinics to Primary Care services.

   An implementation plan for each facility has been developed for the Access and High Utilizer projects. Specific playbooks and implementation plans are being developed for the other projects and are scheduled for startup in September 2015.

2. Family Justice Center – Domestic Violence program:
   This is a potential program which establishes evaluation and short term treatment for victims of domestic violence which will be provided on site at the Family Justice Center program. A meeting has been scheduled with Dr. Catherine Monk who is the director of a similar program at Columbia University. We are in the process of developing a model for this program and a proposal will be finalized for review.
3. NYSOMH / OPWDD (Office of People with Developmental Disabilities) / HHC collaboration:  
   This is a collaboration to explore and develop a specialized treatment program at one of our 
   acute care facilities for people with both mental illness and developmental disabilities. Discussions 
   with OMH are occurring now. We are awaiting utilization data and financial information from 
   OMH. A next step evaluation meeting is to be scheduled.

4. HHC Behavioral Health Incident Review Committee:  
   This is a new committee established to meet the new requirement of the Justice Center. The 
   committee is corporate wide and multidisciplinary and has been set up to review incident data in 
   order to provide guidance to the corporation on trends and management issues. This committee 
   meets every 2 months, the third meeting is scheduled for August.

Office of Patient Centered Care

1. The CNO’s spent an entire day reviewing Epic and are quite pleased with the product. There are 
   issues and processes that are being addressed after their input, but it was a positive experience for 
   the nurses and the Epic team. There are additional meetings scheduled with the nurse educators, 
   infection preventionists and Home Care.

2. HHC was awarded a grant from the Hartford Fund, the funding for which started on July 1st of 
   this year. This grant will allow the enhancement of the role and expertise of registered nurses in 
   the ambulatory Geriatric practices, leveraging NICHE (Nurses Improving Care for Healthsystem 
   Elders), our PCMH and ACO experience.

3. The 2015 Nursing Excellence event will be held on October 27, 2015. Please save this date as all 
   of our nurses always appreciate the participation of our leadership.

Accountable Care Organization

1. The ACO has convened internal management discussions and planning in preparation for 
   reapplication to the Medicare Shared Savings Program for 2016. The ACO is also meeting with 
   affiliates and HHC ACO Board of Directors in coming weeks to ensure satisfaction of CMS 
   submission requirements by the August 7th deadline. The ACO is also exploring expansion of 
   network partnerships to broaden primary care population and capacity in the next application 
   cycle.

2. Roughly 20% of the ACO’s overall population is publically housed in New York City Housing 
   Authority (NYCHA) developments. NYCHA residents have access to various resources and 
   services - crisis intervention, care management, education and counseling, home delivered meals, 
   etc. - that help keep residents healthy in the community. Starting in June, the ACO began 'flagging' 
   patients who reside in public housing. The goal in providing this information is to strengthen 
   connections between HHC facilities, NYCHA, and the community-based organizations (CBOs) 
   that provide services for NYCHA residents - particularly the elderly and disabled. This follows 
   from a pilot with Dr. Judy Flores and the ACO team at Woodhull, who identified ACO patients 
   from three NYCHA developments nearby, then connected ambulatory care/social work 
   leadership with representatives from NYCHA and the CBOs in those locations. The ACO will 
   continue to work to develop streamlined process for referrals and communication.
3. The ACO was recently featured in publications in Crain’s New York and HHC Insider, highlighting the ACO’s population management activities at HHC facilities and the ACO’s policy perspective on changes to the Medicare ACO program structure.

**Laboratory Service**

HHC laboratories is participating in a 3 day Cerner event scheduled 14, 15 and 16th of July, 2015. The event includes review of the HHC Cerner build to date as well vendor training of HHC Super Users from Queens/Elmhurst, Jacobi and North Central Bronx laboratories. Laboratory Services continues to work closely with the EPIC team to insure a seamless communication between the laboratories and the clinical service providers.

**METROPLUS HEALTH PLAN, INC.**

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of June 1, 2015 was 473,905. Breakdown of plan enrollment by line of business is as follows:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>415,887</td>
</tr>
<tr>
<td>Child Health Plus</td>
<td>13,309</td>
</tr>
<tr>
<td>MetroPlus Gold</td>
<td>3,526</td>
</tr>
<tr>
<td>Partnership in Care (HIV/SNP)</td>
<td>4,738</td>
</tr>
<tr>
<td>Medicare</td>
<td>8,446</td>
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<tr>
<td>MLTC</td>
<td>893</td>
</tr>
<tr>
<td>QHP</td>
<td>26,403</td>
</tr>
<tr>
<td>SHOP</td>
<td>601</td>
</tr>
<tr>
<td>FIDA</td>
<td>102</td>
</tr>
</tbody>
</table>

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

NYS Department of Financial Services is continuing to review the 2016 Qualified Health Plan Rates we submitted in May. An answer is expected to be released in the first week of July.

New York Health Plan Alliance released a summary of the most common reasons for discrepancies between issuers (insurers), eMedNY (State enrollment database) and NYSoH (which contribute to member dissatisfaction and therefore potential disenrollment). MetroPlus is facing the same issues as the other participants, namely late renewals, the State’s failure to process 834s, renewal date not available to plans, duplicate accounts, or the State’s failure to submit effectuations.

The MetroPlus Quality Management department is working diligently to collect and submit the 2014 Medicare Star rating data. We predict our score to be the same as the past two years (3.5 stars).

In a previous report to this Committee I mentioned that our growth strategy includes expansion of our network into Staten Island. We have had discussions with the two hospitals in Staten Island – Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC). We expect to finalize rates with RUMC this week. SIUH is more challenging due to its being part of the overall North Shore LIJ network. We are primarily targeting PCPs and high volume specialties. In addition, after mailing over 1,000
Letters to Staten Island providers, we have almost 150 in the credentialing/contracting pipeline. SIUH Physicians and RUMC physician group (Amboy Medical PC) will both be contracted at the same time as the hospital agreements. This will provide over 500 physicians for the network. We also have a relationship with Advantage Care physicians through the Preferred Health Partners group in Brooklyn. They offer two sites in Staten Island with approximately 120 providers who are willing to contract. Pharmacy, Dental and Behavioral Health/Substance Abuse providers are all being addressed through our delegated vendors. We already meet network requirements for Staten Island in these areas.

As of the date of this report, we are undergoing the Onsite BH/HARP Readiness Review. The components of the onsite review are Program Operations (clinical program structure, clinical interviews with Utilization Management and Case Management staff, members services structure and protocols), Information Systems (claims, data warehouse, clinical and telephonic systems), and Document Review (sample of executed provider contracts and corresponding credentialing files, as well as resumes of plan staff participating in interviews). I will provide information about the outcome at the next meeting.

Since I have mentioned the HARP Readiness Review, I will inform you that MetroPlus is also scheduled to undergo the Article 44 Audit at the end of September 2015.

In looking at state-wide data on the Fully-Integrated Dual Advantage (FIDA) program, total enrollment in NYS as of June 2, 2015 was 4,407. There were 47,702 opt-outs. The passive enrollment schedule will enroll 3,908 individuals in July (effectuated June 1, 2015), and 5,584 in August (effectuated July 1, 2015) across the State. In addition, I would like to bring to this committee’s attention that the three-way contract requires plans to move the provider payment agreements from fee-for-service to alternative payment arrangements. We are required to submit proposals for DOH review and approval by August 15, 2015.

Chief Information Officer Report:

Sal Guido, Acting Corporate Chief Information Officer, Enterprise Information Technology Services gave an update on the following: Epic is on time and on budget, ICD10 is on track for deployment on October 1st, and the exchanged email system are all on time.

ACTION ITEM:

Sal Guido, Acting Corporate Chief Information Officer, Enterprise Information Technology Services presented to the committee on the following resolution:

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”) to enter into multiple contracts to purchase health information related professional services for the Epic Electronic Medical Record program and Epic related Revenue Cycle modules as needed with 22 vendors (the “Contractors”) through requirements contracts for a two year term with three one-year options to renew at the Corporation’s exclusive option for an amount not to exceed $119,292,988 million for the initial two year period.

The resolution was approved by the committee to be considered by the board.

INFORMATION ITEM:

Charles Barron, MD, Interim Medical Director of Behavioral Health, Medical and Professional Affairs presented to the committee the Behavioral Health Updates.
Behavioral Health Transformation - Current state

NY State is transitioning to Medicaid managed care with fully integrated behavioral/physical health and specialized Health and Recovery Plans (HARPs) for the seriously ill, between 2015-17 – ending fee-for-service (FFS) reimbursement for carved-out services. Impending changes to BH Medicaid funding could significantly impact HHC. DSRIP has major implications for BH. Given its large BH service, high proportion of Medicaid patients, significant value at risk and strong mission for serving the neediest, our efforts here need strong support. The Largest BH service in NYC (e.g., >40% of total IP discharges). Medicaid FFS accounts for ~52% IP/~40% OP by volume with $250M revenue at risk. HHC has taken significant strides recently to improve its BH service. It’s improved outpatient wait times by 15% as part of ambulatory care access project. It has reduced length of stay (LOS) for inpatient psych by >20% since 2012.

The managed care transformation overall project phases & timeline:
Phase 1 Rapid baselining 9/15/14 to 11/1/14
Phase 2 Solution design Planning 11/1/14 to 1/1/15
Phase 3 Program launch Demonstrate in 4 sites (3 adult, 1 child/adolescent) 1/1/15 to 7/1/15
Phase 4 Standardized pilot roll-out 7/1/15

Phases 2 & 3: Solution Design & Program Launch
“Pillars” of Transformation
Increase use of peers: Strengthen care management; Make care co-occurring capable; Primary care integration; Complete OP and crisis continuum; and Develop community partnerships.

There are 4 Early Adopter Sites - Adult population: Elmhurst, Kings County, Gouverneur Health and Child/Adolescent population: Bellevue.


Pilots and Lessons Learned: Early Adopter Pilots – Kings, Elmhurst, Gouverneur (Adults) and Bellevue (Child)

Lessons Learned - The importance of facility steering committee, Inclusion of Finance, Managed Care, DSRIP, Importance of a site transformation coordinator, Importance of regular weekly team performance meetings, importance of regular monthly steering committee meetings, need for Behavioral Health coach for teams and the need to standardize future pilots across all facilities simultaneously.

Next Steps

To develop new, efficient ambulatory and crisis services including rehabilitation and recovery services as part of the 1915(i) waiver (HCBS – Home and Community Based Services); Accelerate efforts for prepare for Managed behavioral health and HARP; Coordinate above efforts with the DSRIP initiatives - especially integration of primary and BH. These require: changes to both clinical practice and operations strengthened relations with finance, centrally and at facility levels; a stronger culture of continuous quality improvement along with standardization of increased data collection and analysis

There being no further business the meeting was adjourned at 9:56AM.
Thank you and good morning. I’d like to provide the Committee members with several updates:

1. **Soarian Stress Testing:**

I am pleased to report that Information Technology's Business Applications is on target for completing the Soarian Stress testing on September 10, 2015. This testing is in preparation for the Soarian Financials go-live.

Stress testing simulates peak system use using a pre-determined number of users in order to judge the overall performance of the system as well as identifying areas within the system that are performing like bottlenecks. This type of testing ensures that the system has been sized correctly. Through this testing, HHC can remain confident that the Soarian Financials and Scheduling application will perform as expected, especially at peak usage.

Cerner originally estimated delivery of the Soarian test environment to be between August 25th and August 31st. The test environment was delivered on Tuesday, September 1st. Unfortunately, the environment was delivered without any production data which resulted in delays in the development of the necessary automated scripts for the Load test. Both Business Applications and Infrastructure teams created the test scripts after review from Finance and based on input and structure from Cerner which used results from their own internal stress tests. Once completed, these test scripts will run automatically and often repeating their scripted tasks while the tests are performed.

Test scripts will mimic normal user activity on the Soarian system, including admitting, transferring and discharging a patient along with assigning charges for anything related to the patient's visit. Simultaneously, we will have scripts perform look-ups of patients, doctors, as well as run reports similar to normal activity as experienced today.

If successful, this stress testing will prove that the system can handle the extra load that will be placed on it as HHC facilities are placed on the system as well as the added transactional load that will be expected with the Epic integration. With this testing we will also be able to identify any areas that would need to be improved either on the HHC side or Cerner's.

I will report back to the Committee on our progress.
2. **Update on HHC’s Exchange Email System Migration:**

In my June Report to the Committee, I announced that HHC’s Enterprise Infrastructure team was initiating the migration of the HHC workforce from the current Novell Groupwise email system to Microsoft Exchange, establishing one single email system for the entire Corporation. This migration to a more advanced and feature rich email system would provide users with functionality such as instant messaging, mobile applications and integrated and video archiving which was not previously available on the Groupwise email system.

I am pleased to report that at this time over 50% of HHC facilities have either completed or have active migrations underway. Two (2) main factors have caused our slowdown to completing the migration: the need to replace older BlackBerry devices which are no longer supported and the additional time required to plan and prepare for the migration of Correctional Health users to this new platform.

We anticipate that all of HHC will be on the new Exchange platform by November 2015. I will keep the Committee updated on our progress.

3. **ePrescribing (eRX) Go-Live Update:**

ePrescribing (eRX) software officially went live at HHC on Tuesday, August 18, 2015. This software allows for HHC providers to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point of care (Provider). This process is an important element in improving the HHC patient experience by making it easier for our patients to get their medications and reduce medication errors. eRx is also critical to the implementation of our new electronic medical record.
On September 28, 2015, Quadramed will begin to apply an upgrade patch within the ePrescribing module which will address enhancements to renewals of prescriptions and will turn off the ability to add a duplicate pharmacy.

This completes my report today. Thank you.
Resolution

Authorizing the New York City Health and Hospitals Corporation (HHC), through its President, to delegate to each acute care hospital's Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through each hospital's Quality Assurance process to the Board of Directors.

WHEREAS, HHC and its facilities are committed to the delivery of high quality health services in an atmosphere of dignity and respect; and

WHEREAS, the Board of Directors has continuing responsibility for the effective operation of HHC's facilities; and

WHEREAS, the Board of Directors serves as the Governing Body of HHC's facilities;

NOW, THEREFORE, be it

RESOLVED that HHC, through its President, will delegate to each acute care hospital's Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through the Quality Assurance Committee process to the HHC Board of Directors.
EXECUTIVE SUMMARY

Resolution to delegate the review and resolution of patient and family grievances and complaints to patient grievance committees at HHC hospitals

HHC acute care hospital has a well-developed process for responding to concerns raised by patients and their families. HHC’s operating procedure 90-1 sets out the responsibility and authority of the Office of Patient Relations at each HHC facility, and a 1992 resolution sets out additional HHC policies on patients’ rights. These procedures apply to all of the Corporation’s facilities. In addition, the Corporation’s hospitals must adhere to the conditions of participation for hospitals established by the Centers for Medicare and Medicaid (CMS) in 42 CFR § 482.13. (2) (a). The regulation requires that

"The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital’s Governing Body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a Grievance Committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization."

Each HHC acute care hospital has established a committee that reviews and resolves complaints and grievances as defined by CMS. The activities of those committees will be reviewed by the facility hospital-wide quality assurance committee, and data collected regarding patient complaints and grievances must be incorporated in the hospital’s Quality Assessment and Performance Improvement Program. These data are currently reported to the Quality Assurance Committee of the Board of Directors.

This process conforms to every aspect of the regulation except the requirement that the Governing Body delegate responsibility in writing to a Grievance Committee. CMS has cited some HHC hospitals because of the lack of a written delegation from the Governing Body.

This resolution is the written delegation of responsibility required by the CMS regulation. Hereafter complaints and grievances will be reported to the Quality Assurance Committee of the Board of Directors and the hospital’s Governing Body.
Resolution

Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to enter into a sole source agreement with SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed $4,769,555 (which includes a contingency reserve of $229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms.

WHEREAS, New York State Public Health Law and Education Law mandate the implementation of e-prescribing for all medications including controlled substances by March 2016; and

WHEREAS, the Corporation is adopting the Surescripts LLC e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system; and

WHEREAS, Surescripts LLC operates the nation’s only health information network with the capability to electronically transmit prescriptions and refill requests, which network will allow the Corporation to connect the Corporation’s prescribers with community pharmacies in order to enable the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests; and

WHEREAS, the contract with Surescripts LLC will provide all software and services necessary for the Corporation to implement e-prescribing in compliance with NYS mandate requirements; and

WHEREAS, the funding for this contract will be provided through the Epic EMR budget previously presented to the Board of Directors; and

WHEREAS, the contract will be managed and monitored under the direction of the Senior Assistant Vice President/ Interim Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED, THAT the President of New York City Health and Hospitals Corporation be and hereby is authorized to enter into a sole source agreement with SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed $4,769,555 (which includes a contingency reserve of $229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms.
EXECUTIVE SUMMARY

The accompanying Resolution requests approval to enter into a sole source contract with Surescripts LLC (“Surescripts”) for enterprise-wide e-prescribing system in an amount not to exceed $4,769,555 (which includes a contingency reserve of $229,817) for the contract term of 3 years with up to 2 one-year renewals upon mutual consent of the parties. The funding for this contract will be provided through the Epic EMR budget previously presented to the Board of Directors.

New York State Public Health Law and Education Law mandate the implementation of e-prescribing for all medications including controlled substances by March 2016. The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements. HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system.

Enterprise Information Technology Services (“EITS”) received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation’s only health information network with the capability to electronically transmit prescriptions and refill requests. E-Prescribing is the secure transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan. E-Prescribing includes two way transmissions between the point of care and the dispenser.

Surescripts will provide the foundation infrastructure including interface specifications, transaction routing infrastructure, software licenses, participant management services, and error management services. In addition to the prescription routing services to a large network of community pharmacies, Surescripts also connects to a Benefits Manager and Medication History of the patient that further strengthen HHC’s patient safety and patient satisfaction measures.

HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system to enable the Corporation’s prescribers to electronically access:

- the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests to patient designated pharmacies. These pharmacies can be within the HHC facility or neighborhood pharmacies that are not part of the facility.
- patient prescription benefit plan information, both formulary and eligibility, allowing the prescriber to choose medications that are covered by the patient drug benefits at the lowest cost, as a result pharmacies receive fewer prescriptions that require changes;
- with a patient’s consent, electronically access a patient’s medication history to obtain critically important information of the patient’s current and past prescriptions to allow the prescriber to better assess potential medication issues (i.e. potential harmful drug interactions, allergies, adherence) and improve patient safety.
CONTRACT FACT SHEET
New York City Health and Hospitals Corporation

Contract Title: Surescripts E-Prescribing
Project Title & Number: Epic/E-Prescribing
Project Location: EITS
Requesting Dept.: Central Office - EITS

Successful Respondent: SURESCRIPTS LLC
Total Not to Exceed: $4,769,555.41 (includes $229,817.38 contingency)
Contract Term: 3 years with up to 2 one year renewal terms

Number of Respondents: Sole Source
(If Sole Source, explain in Background section)

Range of Proposals: N/A

Minority Business Enterprise Invited: Yes  If no, please explain: N/A

Funding Source:
- ☐ General Care
- ☐ Capital
- ☐ Grant: explain
- ☑ Other: explain

Method of Payment:
- ☑ Lump Sum
- ☐ Per Diem
- ☐ Time and Rate
- ☑ Other: Monthly Fees based on number of Certified Beds as well as additional transaction fees

EEO Analysis: Approved

Compliance with HHC's McBride Principles?
- ☐ Yes
- ☐ No
- ☑ Pending

Vendex Clearance
- ☐ Yes
- ☐ No
- ☑ Pending

(Required for contracts in the amount of $100,000 or more awarded pursuant to an RFP, NA or as a Sole Source, or $100,000 or more if awarded pursuant to an RFB.)
**Background** (include description and history of problem; previous attempts, if any, to solve it; and how this contract will solve it):

This contract is required for the Epic EMR project. New York State Public Health Law and Education Law mandate the implementation of e-prescribing for all medications including controlled substances by March 2016. The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements.

Enterprise Information Technology Services ("EITS") received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation’s only health information network with the capability to electronically transmit prescriptions and refill requests. E-Prescribing is the secure transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan. E-Prescribing includes two way transmissions between the point of care and the dispenser.

**Contract Review Committee**

*Was the proposed contract presented at the Contract Review Committee (CRC)? (Include date):*

CRC approval was received to initiate negotiations for a sole source contract with Surescripts LLC in November 2012.

*Has the proposed contract’s scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC? If so, please indicate how the proposed contract differs since presentation to the CRC:*

N/A.
**Selection Process** (attach list of selection committee members, list of firms responding to RFP or NA, list of firms considered, describe here the process used to select the proposed contractor, the selection criteria, and the justification for the selection):

This is a sole source contract.

Enterprise Information Technology Services (“EITS”) received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation’s only health information network with the capability to electronically transmit prescriptions and refill requests.

**Scope of work and timetable:**

Surescripts will provide the software and services necessary for the foundation infrastructure including interface specifications, transaction routing infrastructure; participant management services, and error management services. In addition to the prescription routing services to a large network of community pharmacies, Surescripts also connects to a Benefits Manager and Medication History of the patient that further strengthen HHC’s patient safety and patient satisfaction measures.

HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system to enable the Corporation’s prescribers to electronically access:

- the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests to patient designated pharmacies. These pharmacies can be within the HHC facility or neighborhood pharmacies that are not part of the facility;

- patient prescription benefit plan information, both formulary and eligibility, allowing the prescriber to choose medications that are covered by the patient drug benefits at the lowest cost, as a result pharmacies receive fewer prescriptions that require changes;

- with a patient’s consent, electronically access a patient’s medication history to obtain critically important information of the patient’s current and past prescriptions to allow the prescriber to better assess potential medication issues (i.e. potential harmful drug interactions, allergies, adherence) and improve patient safety.
Provide a brief costs/benefits analysis of the services to be purchased.

E-Prescribing is a regulatory requirement.

The costs of the contract for the five year period is $4,769,555.41 which includes a contingency of $229,817.38. The annual cost is based on 3,181 Certified beds, billable monthly at the rate of $136.00 per bed for the approximately 3,181 Certified beds (HHC Corporate Planning Services, prepared 2/13/2015) within the Corporation’s facilities. Other components and transaction fees include:

- One Time Fees – Staging fee $1,500 and $25,000 to establish connectivity to the Surescripts system to meet Clinical Network Services requirements.
- Faxing fees, Prior Authorizations for registered providers and Clinical Network services fees – all fees have been incorporated into the total 5 year budget.

Provide a brief summary of historical expenditure(s) for this service, if applicable.

Not applicable.

Provide a brief summary as to why the work or services cannot be performed by the Corporation’s staff.

E-Prescribing is a regulatory requirement.

Will the contract produce artistic/creative/intellectual property? Who will own it? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

Not applicable.

Contract monitoring (include which Senior Vice President is responsible):

This contract will be administered by Sal Guido, Senior AVP / Interim CIO.

Equal Employment Opportunity Analysis (include outreach efforts to MBE/WBE’s, selection process, comparison of vendor/contractor EEO profile to EEO criteria. Indicate areas of under-representation and plan/timetable to address problem areas):

Received By E.E.O. _____ 5/19/14 ____________ Date

Analysis Completed By E.E.O. _____ 9/2/14 ____________ Date

_______________ Manasses Williams, Senior AVP ________________

Name
Surescripts Sole Source Contract

Medical & Professional Affairs/
IT Committee
9/10/2015
Overview

• e-Prescribing – Background 3
• Purpose of the Contract 4
• Surescripts sole source provider 5
• Estimated Cost by Fiscal Year 6
• 6 Year Epic Implementation Budget 7
• Questions
e-Prescribing – Background

• The CMS definition of e-prescribing “…the transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two way transmissions between the point of care and the dispenser.”

• The New York State Public Health Law and the Education Law mandate the implementation of electronic prescribing by March 27, 2016.

• The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements. HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system.

• Surescripts operates the nation’s largest health information network with the capability to electronically transmit prescriptions and refill requests.
The purpose of the contract is to procure the essential Surescripts e-prescribing software and services that uniquely provides the following benefits:

- **Electronically Access That Patient's Prescription Benefit Information**: Prescribers can choose medications that are covered by the patient's drug benefit as well as those of lower-cost. Pharmacies receive fewer prescriptions that require changes.

- **With a Patient's Consent, Electronically Access that Patient's Medication History**: Prescribers receive critically important information on their patients' current and past prescriptions which assists with patient safety. Prescribers can also gain insight into a patient's medication compliance.

- **Electronically Route the Prescription to the Patient's Choice of Pharmacy**: Exchanging prescription information electronically between prescribers and pharmacies improves the accuracy of the prescribing process reducing the need for pharmacy staff to key in prescription data reducing errors.
Surescripts Sole Source Provider
Estimated Costs By Fiscal Year

<table>
<thead>
<tr>
<th>Contract Year</th>
<th>$ Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 *</td>
<td>$876,616</td>
</tr>
<tr>
<td>Year 2</td>
<td>$875,619</td>
</tr>
<tr>
<td>Year 3</td>
<td>$901,842</td>
</tr>
<tr>
<td>Year 4 (Renewal)</td>
<td>$928,897</td>
</tr>
<tr>
<td>Year 5 (Renewal)</td>
<td>$956,764</td>
</tr>
<tr>
<td>Contingency</td>
<td>$229,817</td>
</tr>
<tr>
<td><strong>Five Year Estimated Total</strong></td>
<td><strong>$4,769,555</strong></td>
</tr>
</tbody>
</table>

* Assumes 10/1/15 start date. Year One includes initial one time fees.
## 6 Year Epic EMR Implementation Budget

### EMR Project - Six Year Implementation Budget

[Expenditures include Invoices Paid or In-Process]

<table>
<thead>
<tr>
<th>Item</th>
<th>Total Implementation Dollars (in millions)</th>
<th>Total Budget</th>
<th>Expenditures [Paid or in Process] as of 07/31/2015</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Epic Contract</strong></td>
<td></td>
<td>$144</td>
<td>$66</td>
<td>$78</td>
</tr>
<tr>
<td><strong>2 Third Party &amp; Other Software</strong></td>
<td></td>
<td>$30</td>
<td>$4</td>
<td>$26</td>
</tr>
<tr>
<td><strong>3 Hardware</strong></td>
<td></td>
<td>$84</td>
<td>$26</td>
<td>$58</td>
</tr>
<tr>
<td><strong>4 Interfaces</strong></td>
<td></td>
<td>$39</td>
<td>$4</td>
<td>$35</td>
</tr>
<tr>
<td><strong>5 Implementation Support</strong></td>
<td></td>
<td>$355</td>
<td>$37</td>
<td>$318</td>
</tr>
<tr>
<td><strong>6 Application Support Team</strong></td>
<td></td>
<td>$113</td>
<td>$29</td>
<td>$84</td>
</tr>
</tbody>
</table>

| Clinicals-Only Total  | [Without QuadraMed Transition/Existing Application/Existing Staff Costs] | $764         | $165                                             | $599    |

**Note:**
1. 5 year current cost projection for Revenue Cycle was an additional $125 million. Budget is under review. Further evaluation required.
2. $154 million has been paid through 7/31/15. An additional $11 million is in process to be paid for a total of $165 million.
Questions
MetroPlus Health Plan, Inc.

Report to the New York City Health and Hospitals Corporation’s Medical and Professional Affairs Committee

Arnold Saperstein, MD
Executive Director, MetroPlus Health Plan
September 10, 2015
Contents

- Membership
- Growth Initiatives
- Exchange (QHP) Pricing and Membership
- Provider Network
- HHC Financial Arrangement
- Consumer Guide Results
- 2015 Changes: FIDA, HARP, EP
- Challenges
- Summary
MetroPlus Membership

- Membership at 473,340 as of August 1, 2015.

<table>
<thead>
<tr>
<th>LOB</th>
<th>January 1, 2015</th>
<th>August 1, 2015</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>409,118</td>
<td>418,016</td>
<td>2.17%</td>
</tr>
<tr>
<td>CHP</td>
<td>12,124</td>
<td>12,432</td>
<td>2.54%</td>
</tr>
<tr>
<td>HHC</td>
<td>3,629</td>
<td>3,560</td>
<td>-1.90%</td>
</tr>
<tr>
<td>SNP</td>
<td>4,891</td>
<td>4,676</td>
<td>-4.40%</td>
</tr>
<tr>
<td>Medicare</td>
<td>8,559</td>
<td>8,469</td>
<td>-1.05%</td>
</tr>
<tr>
<td>MLTC</td>
<td>806</td>
<td>875</td>
<td>8.56%</td>
</tr>
<tr>
<td>QHP</td>
<td>22,442</td>
<td>24,754</td>
<td>10.30%</td>
</tr>
<tr>
<td>SHOP</td>
<td>685</td>
<td>483</td>
<td>-29.49%</td>
</tr>
<tr>
<td>FIDA</td>
<td>4</td>
<td>177</td>
<td>4325.00%</td>
</tr>
<tr>
<td>Total</td>
<td>462,258</td>
<td>473,442</td>
<td>2.42%</td>
</tr>
</tbody>
</table>

Primary Care Assignment

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HHC</td>
<td>52.91%</td>
</tr>
<tr>
<td>Community</td>
<td>47.09%</td>
</tr>
</tbody>
</table>
Growth Initiatives

• Expansion to Staten Island

• Office of Labor Relations - make MetroPlus available to all NYC employees

• Aggressive Exchange pricing for 2016

• DSRIP Project 11
## Exchange Product Pricing - 2016
### Silver

<table>
<thead>
<tr>
<th>Premium Rates</th>
<th>2015</th>
<th>2016</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metal/Tier</td>
<td>Company</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silver</td>
<td>Metro Plus</td>
<td>382.57</td>
<td>369.04</td>
</tr>
<tr>
<td>Silver</td>
<td>Affinity</td>
<td>371.75</td>
<td>394.73</td>
</tr>
<tr>
<td>Silver</td>
<td>North Shore LIJ</td>
<td>394.00</td>
<td>406.04</td>
</tr>
<tr>
<td>Silver</td>
<td>Fidelis (NYS Cath)</td>
<td>383.54</td>
<td>408.04</td>
</tr>
<tr>
<td>Silver</td>
<td>HealthFirst</td>
<td>387.46</td>
<td>422.41</td>
</tr>
<tr>
<td>Silver</td>
<td>Wellcare</td>
<td>476.31</td>
<td>448.54</td>
</tr>
<tr>
<td>Silver</td>
<td>Emblem HIP</td>
<td>407.28</td>
<td>452.79</td>
</tr>
<tr>
<td>Silver</td>
<td>Oscar</td>
<td>434.96</td>
<td>466.68</td>
</tr>
<tr>
<td>Silver</td>
<td>Health Republic</td>
<td>428.64</td>
<td>486.96</td>
</tr>
<tr>
<td>Silver</td>
<td>MVP HP</td>
<td>432.46</td>
<td>487.66</td>
</tr>
<tr>
<td>Silver</td>
<td>Empire HMO</td>
<td>471.19</td>
<td>553.45</td>
</tr>
<tr>
<td>Silver</td>
<td>UHNY</td>
<td>544.76</td>
<td>555.37</td>
</tr>
<tr>
<td>Silver</td>
<td>Oxford OHP</td>
<td>627.50</td>
<td>555.97</td>
</tr>
</tbody>
</table>
# Exchange Product Pricing - 2016

## Platinum

<table>
<thead>
<tr>
<th>Metal/Tier</th>
<th>Company</th>
<th>2015</th>
<th>2016</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>Metro Plus</td>
<td>515.08</td>
<td>505.65</td>
<td>-2%</td>
</tr>
<tr>
<td>Platinum</td>
<td>Affinity</td>
<td>517.42</td>
<td>549.08</td>
<td>6%</td>
</tr>
<tr>
<td>Platinum</td>
<td>North Shore LIJ</td>
<td>513.00</td>
<td>556.32</td>
<td>8%</td>
</tr>
<tr>
<td>Platinum</td>
<td>HealthFirst</td>
<td>537.48</td>
<td>592.00</td>
<td>10%</td>
</tr>
<tr>
<td>Platinum</td>
<td>Fidelis(NYS Cath)</td>
<td>580.06</td>
<td>607.42</td>
<td>5%</td>
</tr>
<tr>
<td>Platinum</td>
<td>Wellcare</td>
<td>619.34</td>
<td>615.43</td>
<td>-1%</td>
</tr>
<tr>
<td>Platinum</td>
<td>Oscar</td>
<td>591.32</td>
<td>637.67</td>
<td>8%</td>
</tr>
<tr>
<td>Platinum</td>
<td>Emblem HIP</td>
<td>600.98</td>
<td>649.27</td>
<td>8%</td>
</tr>
<tr>
<td>Platinum</td>
<td>MVP HP</td>
<td>610.55</td>
<td>667.12</td>
<td>9%</td>
</tr>
<tr>
<td>Platinum</td>
<td>Health Republic</td>
<td>588.92</td>
<td>668.88</td>
<td>14%</td>
</tr>
<tr>
<td>Platinum</td>
<td>Empire Assur.</td>
<td></td>
<td>746.60</td>
<td></td>
</tr>
<tr>
<td>Platinum</td>
<td>Empire HMO</td>
<td>665.90</td>
<td>750.82</td>
<td>13%</td>
</tr>
<tr>
<td>Platinum</td>
<td>UHNY</td>
<td>759.87</td>
<td>773.64</td>
<td>2%</td>
</tr>
<tr>
<td>Platinum</td>
<td>Oxford OHP</td>
<td>875.58</td>
<td>774.48</td>
<td>-12%</td>
</tr>
</tbody>
</table>
### Current Exchange Membership

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>Benefit Type</th>
<th>0 to 19</th>
<th>20 to 35</th>
<th>36 to 49</th>
<th>50 to 59</th>
<th>60+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>Non-Standard</td>
<td>5</td>
<td>356</td>
<td>271</td>
<td>220</td>
<td>103</td>
<td>955</td>
</tr>
<tr>
<td>Bronze</td>
<td>Standard</td>
<td>8</td>
<td>80</td>
<td>87</td>
<td>73</td>
<td>38</td>
<td>286</td>
</tr>
<tr>
<td>Gold</td>
<td>Non-Standard</td>
<td>30</td>
<td>410</td>
<td>445</td>
<td>296</td>
<td>155</td>
<td>1,336</td>
</tr>
<tr>
<td>Gold</td>
<td>Standard</td>
<td>13</td>
<td>99</td>
<td>117</td>
<td>116</td>
<td>63</td>
<td>408</td>
</tr>
<tr>
<td>Platinum</td>
<td>Non-Standard</td>
<td>40</td>
<td>531</td>
<td>701</td>
<td>582</td>
<td>336</td>
<td>2,190</td>
</tr>
<tr>
<td>Platinum</td>
<td>Standard</td>
<td>41</td>
<td>111</td>
<td>149</td>
<td>124</td>
<td>78</td>
<td>503</td>
</tr>
<tr>
<td>Silver</td>
<td>Non-Standard</td>
<td>69</td>
<td>5,545</td>
<td>4,314</td>
<td>3,601</td>
<td>1,814</td>
<td>15,343</td>
</tr>
<tr>
<td>Silver</td>
<td>Standard</td>
<td>89</td>
<td>1,144</td>
<td>1,011</td>
<td>986</td>
<td>539</td>
<td>3,717</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>243</td>
<td>8,282</td>
<td>7,095</td>
<td>5,998</td>
<td>3,126</td>
<td>24,744</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>% of Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>243</td>
</tr>
<tr>
<td>20-35</td>
<td>8,282</td>
</tr>
<tr>
<td>36-49</td>
<td>7,095</td>
</tr>
<tr>
<td>50-59</td>
<td>5,998</td>
</tr>
<tr>
<td>60+</td>
<td>3,126</td>
</tr>
<tr>
<td>Total</td>
<td>24,744</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>% of Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>4,914</td>
</tr>
<tr>
<td>Non-Standard</td>
<td>19,824</td>
</tr>
<tr>
<td>Total</td>
<td>24,744</td>
</tr>
</tbody>
</table>

*non-standard products include the essential health benefits with the voluntary addition for dental and vision care
## Provider Network

<table>
<thead>
<tr>
<th>MetroPlus Network Sites</th>
<th>12/3/2013</th>
<th>8/1/2014</th>
<th>% Change</th>
<th>8/1/2015</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Providers (PCPs)</td>
<td>3,357</td>
<td>3,649</td>
<td>8.70</td>
<td>3,944</td>
<td>8.08%</td>
</tr>
<tr>
<td>Specialty Providers</td>
<td>13,260</td>
<td>16,259</td>
<td>22.62</td>
<td>17,638</td>
<td>8.48%</td>
</tr>
<tr>
<td>OB / GYN</td>
<td>757</td>
<td>728</td>
<td>(3.83)</td>
<td>779</td>
<td>7.01%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17,374</td>
<td>20,636</td>
<td>18.78</td>
<td>22,361</td>
<td>8.36%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2Q 2011</th>
<th>2Q 2012</th>
<th>2Q 2013</th>
<th>2Q 2014</th>
<th>2Q 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHC PCPs</td>
<td>526</td>
<td>517</td>
<td>554</td>
<td>540</td>
<td>546</td>
</tr>
</tbody>
</table>

*HHC PCPs*" represents unique HHC PCPs. If a PCP is at multiple locations, for the purpose of this report, he/she is only counted once.
Consumer’s Guide to Medicaid Managed Care in NYC: MetroPlus Ranking

- MetroPlus has been rated #1 Medicaid Managed Care health plan in NYC for seven out of the last 10 years*. For the first time ever, in 2011 MetroPlus was ranked #1 in New York State and New York City.

<table>
<thead>
<tr>
<th>Year</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>2nd</td>
</tr>
<tr>
<td>2013</td>
<td>2nd</td>
</tr>
<tr>
<td>2012</td>
<td>1st</td>
</tr>
<tr>
<td>2011</td>
<td>1st</td>
</tr>
<tr>
<td>2010</td>
<td>1st</td>
</tr>
<tr>
<td>2009</td>
<td>1st</td>
</tr>
<tr>
<td>2008</td>
<td>2nd</td>
</tr>
<tr>
<td>2007</td>
<td>1st</td>
</tr>
<tr>
<td>2006</td>
<td>1st</td>
</tr>
<tr>
<td>2005</td>
<td>1st</td>
</tr>
</tbody>
</table>

* Based on indicators chosen by the New York State Department of Health (NYSDOH) and published in the Consumer’s Guide to Medicaid Managed Care in New York City.
2015 Changes

- FIDA - January 1, 2015
- HARP - October 1, 2015
- Essential Plan (formerly known as Basic Health Plan) - 2015 Open Enrollment Period - effective January 1, 2016
  - Four products - based on FPL (up to 200% FPL)
  - Aliessa population
FIDA is a partnership between the State of NY and CMS to test a new model for providing Medicare-Medicaid enrollees with a more coordinated, person centered care experience.

- Poor enrollment state-wide and high rate of opt outs
  - Approximately 47,702 eligible individuals opted out of FIDA
  - Approximately 43,000 eligible individuals have not opted out; therefore they can potentially be passively enrolled.
  - There are 4,407 enrollments across the 21 plans state-wide.

- Challenge: long and burdensome training prevents providers from being engaged in all the required sections.
Health and Recovery Plan (HARP)

- Carve-in of Behavioral Health for SSI members (17,000).
- Creation of a Health and Recovery Plan (HARP) for the severely mentally ill population (13,000).
- Going live October 1, 2015.
- MetroPlus received Conditional Approval following on-site audit
Essential Plan (EP)

- EP will utilize MAGI rules and provide people with temporary eligibility pending verification of information.
- Effective Date of Enrollment - EP will follow the 15th of the month rule for enrollment.
- Individuals must report changes that could effect eligibility throughout the year.
- Enrollment will be open all year.
- Applications for EP coverage in 2016 will be processed starting on October 1, 2015.
Challenges

• Securing access for our new Exchange membership
  - 52.64% of Exchange members are assigned to HHC for Primary Care
  - 52.91% of all members are assigned to HHC for Primary Care
• Temporary Exchange membership auto-assignment adjustment based on access availability
• Significant Exchange members’ discontent with clinic environment
• Maximizing and enhancing member retention through focused evaluation of current retention tactics
• Highly competitive and rapidly changing healthcare landscape and market.
Summary

• MetroPlus is a strong financial asset to HHC

• MetroPlus is challenged by the lack of access in the HHC facilities

• MetroPlus and HHC have many opportunities to strengthen their existing partnerships to ensure continued success
  - Medicare Enrollment
  - Access Improvement
  - Care Management Linkages
  - MLTC Referrals
  - FIDA Referrals
  - HARP Referrals
  - DSRIP Project 11
Patient Safety Update 2015

Mei Kong, RN, MSN
Assistant Vice President,
Office of Patient Safety and Employee Safety

M&PA IT Committee
Thursday, September 10, 2015
Patient Safety Update

Overarching Goal: Foster a high reliability culture of safe practices across HHC to reduce harm or potential harm to our patients and staff

HHC’s 2020 Strategic Goals
- Improve Patient Experience
- Improve Access
- Increase Market Share
- Ensure Financial Strength

Process Design
Patient and Family Partnerships
Reliability Culture
Human Factors Integration
Partnerships with External Agencies and Labor Unions
Process Design

- Anticoagulant Handbook for Clinicians – Version 2.0
- Managing Hyperglycemia in the Hospitalized Adult Patient Handbook
- Electronic Medication Intervention:
  - Total interventions 74,438 (2014) vs. 58,687 (2013)
  - Clinical Recommendations – 13,656
  - Order clarification – 7,666
  - Duplication of Therapy/Order – 7,557
- Adverse Drug Reaction (ADR) – New Electronic Database

- Educate staff on strategies for working effectively with aggressive patients safely:
  - Utilizing TeamSTEPPS Strategies and Tools to Deescalate Violence (non-violent crisis intervention) and Prevent Harm
  - Bellevue Forensic Psychiatry Unit baseline 1st Q 2014 violence rate - 8.76%. Post intervention 2ndQ=0.82%, 3rd Q=0.41%, and 4thQ=0.43%
  - Patient assault against staff 1st Q 2014 benchmark of 3.1 per 1,000 bed days. Post intervention decreased to 2ndQ= 1.4, 3rdQ=1.9, and 4thQ=0.8 per 1,000 bed days
  - TeamSTEPPS and Escalation

- Joint Labor-Management Forum – HHC and CIR/SEIU
  - Working with Disruptive Patient Behaviors While Keeping Safe

- Coler - Reduction in Falls and Injury Prevention Rates:
  - NYS Average 3.2% (EQUIP for Quality- MDS Data)
    - CY12 = 2.1%; CY13 = 2%; CY14 = 1.1%; CY15 Q1 & Q2 = 0.6%
  - Queens Hospital – Blood Bank Safety – reduced discarded mismatched specimens by eliminating type and screen requisition form. All type and screen orders placed in QuadraMed will generate bar code specimen labels only.
  - Coney Island – Close Call Identification Program (CCIP) – CCI Safety Pyramid, executive walkrounds, and developed an electronic anonymous reporting system
Adverse Drug Reaction (ADR) Electronic Database
Patient and Family Partnerships

- Reduction of Antipsychotic Medication in LTC Dementia Population Utilizing Novel Non-Pharmacological Approaches
  NYS Average 19.3% (EQUIP for Quality- MDS Data)
  - Coler – CY11 = 15.6%; CY12 = 11.4%; CY13 = 10.3%; CY14 = 9.8%; CY15 Q1 & Q2 = 2.4%

- Patient Engagement Through Health Literacy - Take the Pledge. Take Your Meds (Woodhull Medical Center)

- Patient Experience - Communication About Medications (Bellevue Hospital)

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Patient Involvement Survey

- “Just-in-time” tool to objectively assess patients’ perception of involvement in their care
- Translated into 12 languages
- 6,908 surveys completed in CY 2014
Medication Safety

Woodhull Patient Engagement Through Health Literacy

TAKE THE PLEDGE. TAKE YOUR MEDS.

<table>
<thead>
<tr>
<th>POCKET JOURNAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MY MEDICINES</td>
</tr>
<tr>
<td>Medicine</td>
</tr>
<tr>
<td>Example</td>
</tr>
</tbody>
</table>

- Refill date: How much do I take? When do I take it?

<table>
<thead>
<tr>
<th>QUESTIONS TO ASK MY DOCTOR/PHARMACIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the name of the medicine?</td>
</tr>
<tr>
<td>2. Why do I need this medicine? (What does it do and why should I take it?)</td>
</tr>
<tr>
<td>3. How much?</td>
</tr>
<tr>
<td>4. When and how should I take this medicine?</td>
</tr>
<tr>
<td>5. Can I stop taking it if I feel better?</td>
</tr>
<tr>
<td>6. Are there any side effects?</td>
</tr>
<tr>
<td>7. Is it safe to take it with other medicines or vitamins?</td>
</tr>
</tbody>
</table>

- Pocket Journal available in English/Spanish and English/Polish designed to aid patients in keeping track of important contacts and medication list.

- **One page flyer** translated into Spanish and Polish, includes important contact numbers and questions to prompt the patient to ask their provider about their medicine.

- **Pocket Journal** available in English/Spanish and English/Polish designed to aid patients in keeping track of important contacts and medication list.
Medication Communication “Script”

Key Changes

New Medication Communication Script for RN’s
- Let’s talk about the new medication that your doctor prescribed for you.
- It’s called: (Med Name - - -).
- Its purpose is to (Med Purpose - - -).
- Just like any medication, (Med Name - - -) can have possible side effects.
- What I mean by side effects is that even though (Med Name - - -) is to help you with (Med Purpose - - -), you might also feel: Side effect #1, . . . . . or Side effect #2, . . . . . or Side effect #3, . . . .
- Do you have any questions or concerns about the purpose of your new medication or its side effects?

Please, ask us!

Key Changes

Medical House Staff and Nursing Staff - New Standard Worksheets

<table>
<thead>
<tr>
<th>UNIT</th>
<th>Baseline</th>
<th>Target</th>
<th>June 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>16E Top Box Scores</td>
<td>49</td>
<td>60</td>
<td>58.5</td>
</tr>
<tr>
<td>17N Top Box Scores</td>
<td>66</td>
<td>75</td>
<td>67.9</td>
</tr>
</tbody>
</table>

Patient Survey Results:

Q. Did your nurse talk to you about med side effects? (YES)

22 (n=18) 75

Q. Did your doctor discuss with you what medications you should take when you go home? (YES)

50 (n=10) 100

98% (N=52/53)

House Staff Survey Results:

Q. Talk to RN about discharge prescriptions? (YES)

56 (n=16) 100

100% (N=53/53)

Q. Talk to patient about discharge prescriptions? (YES)

69 (n=16) 100

100% (N=53/53)
Human Factors Integration

- Surgical Checklist – Elmhurst Hospital
- Compliance with key elements (8)
  1. Cessation of activity during brief
  2. Cessation of activity during time-out
  3. Image verification during brief
  4. Image verification during time-out
  5. Safety statement by the surgeon
  6. Procedure verification
  7. Patient verification
  8. Communication

- Completion Plan
  - Increase OR senior leaders visibility
  - Escalation procedure to address non-compliance
  - Dialogue with directors of service and their staff
  - Establish observation target

- HHC Office of Patient Safety and Employee Safety partnered with Kerm Henriksen, Ph.D., Human Factors Advisor for Patient Safety at Agency for Healthcare Research and Quality and developed:
  - Human Factors Evaluation Algorithm
  - Human Factors Evaluation Worksheet

1. I am treated with dignity and respect by everyone at work?
2. I have what I need, in order to make a contribution that gives meaning to my work life?
3. I am recognized and thanked for what I do at work?
## Human Factors Integration

### Staff Engagement - Joy and Meaning at Work

<table>
<thead>
<tr>
<th>Date</th>
<th>Answer</th>
<th>I am treated with dignity and respect by everyone at work</th>
<th>I have what I need, in order to make a contribution that gives meaning to my work life?</th>
<th>I am recognized and thanked for what I do at work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical residents 2013-2014</td>
<td>Yes</td>
<td>466 64%</td>
<td>No Data</td>
<td>461 64%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>264 36%</td>
<td>No Data</td>
<td>260 36%</td>
</tr>
<tr>
<td>Q2-2013</td>
<td>Yes</td>
<td>31 44%</td>
<td>46 73%</td>
<td>45 70%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>39 56%</td>
<td>17 27%</td>
<td>19 30%</td>
</tr>
<tr>
<td>Q2-2014</td>
<td>Yes</td>
<td>86 49%</td>
<td>102 63%</td>
<td>59 34%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>90 51%</td>
<td>59 37%</td>
<td>116 66%</td>
</tr>
<tr>
<td>Q3-2014</td>
<td>Yes</td>
<td>34 36%</td>
<td>50 66%</td>
<td>43 46%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>61 64%</td>
<td>26 34%</td>
<td>50 54%</td>
</tr>
<tr>
<td>Q4-2014</td>
<td>Yes</td>
<td>91 42%</td>
<td>140 63%</td>
<td>112 51%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>125 58%</td>
<td>82 37%</td>
<td>107 49%</td>
</tr>
<tr>
<td>Q1-2015</td>
<td>Yes</td>
<td>41 34%</td>
<td>73 64%</td>
<td>64 50%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>78 66%</td>
<td>41 36%</td>
<td>64 50%</td>
</tr>
<tr>
<td>Q2-2015</td>
<td>Yes</td>
<td>70 58%</td>
<td>77 61%</td>
<td>63 51%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>50 42%</td>
<td>50 39%</td>
<td>60 49%</td>
</tr>
<tr>
<td>Q3-2015</td>
<td>Yes</td>
<td>67 42%</td>
<td>87 55%</td>
<td>73 47%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>93 58%</td>
<td>70 45%</td>
<td>83 53%</td>
</tr>
<tr>
<td>Total</td>
<td>Yes</td>
<td>886 53%</td>
<td>575 63%</td>
<td>920 55%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>800 47%</td>
<td>345 38%</td>
<td>759 45%</td>
</tr>
</tbody>
</table>

Total responses: 1686, 920, 1679

All other staff: physicians, nurses, hospital police, human resources, behavioral health associates, etc.
Human Factors Integration

Human Factors Evaluation Algorithm

- To provide a systems approach when reviewing causative factors
- To provide additional information when evaluating failure type(s)

Human Factors Evaluation Algorithm

- Process
  - Failure Possible
  - Failure Reocurrence
  - Define the Type of Human Factors / Issues
    - Examples:
      - Incorrect action by user
      - Work overload/under load
      - Insufficient training
      - Inadequate resources
      - Inadequate procedures
      - Inadequate labeling
      - Equipment not easily operable
      - Display/controls confusing
      - Displays/controls no accessible/useable
      - Inadequate communications
      - Fear of speaking up
      - Leadership support
      - Environmental issues (temperature, humidity, light, noise, distractions)
      - Error (wrong action, no specific reason)
      - Mistake (wrong action, misunderstood)
      - Other?
  - Develop Protective Measures and Implementation Steps
  - Monitoring / Outcome

- People
- Processes and Procedures
- Equipment
- Physical Environment
- Organizational Climate

Human Factors Evaluation Worksheet

<table>
<thead>
<tr>
<th>People</th>
<th>Processes and Procedures</th>
<th>Equipment</th>
<th>Physical Environment</th>
<th>Organizational Climate</th>
</tr>
</thead>
</table>

- Define the Type of Human Factors / Issues
- Define contributing factors to the failure
- Provide Protective Measures and Implementation Steps
- Monitor / Outcome
- Most frequently identified root causes of Sentinel Events reviewed by the Joint Commission 2014 (n=764)
Reliability Culture

- Just Culture Certification Course – 3 Days
  Provides a comprehensive overview of the fundamental elements of 5 skills for producing better outcomes:
  1. Identifying values and setting expectations
  2. Improving system design
  3. Managing behavioral choices
  4. Building and utilizing robust learning system
  5. Ensuring justice and accountability – The Just Culture Algorithm

  90 passed the examination – This cadre of individuals will be the resident experts and provide Just Culture consultation as needed in their facilities

  Participants included: Chief Nurses/Physicians & Designees, Patient Safety Officers/Assoc., Human Resources, Labor Relations, Risk Management, Administrators, Hospital Police

- High Reliability Organization – Self Assessment
  - Leadership
  - Safety Culture
  - Performance Improvement

Participants included:
SVP/ED, CMO, CNO, COO, CFO, Director of Quality/Risk Manag./Pharm/Social Work, PSO, Chief of Services (med,ED, Surg, Psych, OB/GYN, HNs, ADNs, Supv.)
High Reliability Organization Survey Tool

Safety Culture

<table>
<thead>
<tr>
<th>Trust</th>
<th>Accountability</th>
<th>Safety Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
</tr>
</tbody>
</table>

Leadership

<table>
<thead>
<tr>
<th>HRD Characteristic</th>
<th>Component</th>
<th>Stages of Maturity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board</td>
<td>CEO/Management</td>
<td>Leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality Strategy</td>
</tr>
<tr>
<td></td>
<td>Physicians</td>
<td>Quality Measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Information Technology</td>
</tr>
</tbody>
</table>

Performance Improvement

<table>
<thead>
<tr>
<th>Methods</th>
<th>Organization has not adopted a formal approach to quality management.</th>
</tr>
</thead>
</table>

Exploration of modern process improvement tool begin. |

Organization commits to adopt the full suite of Robust Process Improvement (RPI) tools. |

Adoption of RPI tools is accepted fully throughout the organization. |

Spread

No commitment to widespread adoption of improvement methods tools. |

RPIs used in many areas to improve business processes as well as clinical quality and safety. POSITIVE ROIs achieved. |

RPI tools are used throughout the organization for all improvement work; patients are engaged in redesigning care processes, and improvement is required for career advancement. |

Title:

Assessing Your Organization’s Potential to Become a High Reliability Organization

<table>
<thead>
<tr>
<th>Board</th>
<th>Check-off below</th>
<th>Check-off below</th>
<th>Check-off below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CEO/Management</th>
<th>Check-off below</th>
<th>Check-off below</th>
<th>Check-off below</th>
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<tr>
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<table>
<thead>
<tr>
<th>Leadership</th>
<th>Check-off below</th>
<th>Check-off below</th>
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</thead>
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<tr>
<td>Check-off below</td>
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<td>Check-off below</td>
<td>Check-off below</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Strategy</th>
<th>Quality is not identified as a central strategic imperative.</th>
<th>Quality is one of many competing strategic priorities.</th>
<th>Quality is one of the organization’s top three strategic priorities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>Quality measures are not prominently displayed or reported internally or publicly; the only measures used are those required by outside entities and are not part of reward systems.</th>
<th>Quality measures are prominently displayed and are a part of the system.</th>
<th>Quality measures are prominently displayed and are a part of the system.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Technology</th>
<th>IT provides lots of no support for quality improvement.</th>
<th>It supports some improvement activities, but the principles of safe adoption are not followed.</th>
<th>It supports some improvement activities, but the principles of safe adoption are not followed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
<td>Check-off below</td>
</tr>
</tbody>
</table>
High Reliability Organization Survey Tool

HRO Safety Culture Indicator Results
Acute Care (n=363) and Long Term Care (n=63)
Stages of Organizational Maturity: Beginning (1), Developing (2), Advancing (3), Approaching (4)

HRO Performance Improvement Indicator Results
Acute Care (n=363) and Long Term Care (n=63)
Stages of Organizational Maturity: Beginning (1), Developing (2), Advancing (3), Approaching (4)

HRO Leadership Indicator Results
Acute Care (n=363) and Long Term Care (n=63)
Stages of Organizational Maturity: Beginning (1), Developing (2), Advancing (3), Approaching (4)

HRO Self Assessment Results from Acute Care, Long Term Care and HHC total
Stages of Organizational Maturity: Beginning (1), Developing (2), Advancing (3), Approaching (4)
Going Forward

- Patient Safety Exposition – September 21st at HHC Conference Center at Jacobi Medical Center
- Implement Electronic Adverse Drug Reaction (ADR) Database
- Joint Labor-Management Forum – CIR/SEIU
- Work with senior leaders to expand visiting hours
- Affordable Care Act PSO Mandate
  - January 1, 2017, qualified health plans in insurance exchanges may not contract with a hospital of 50 beds or more unless that hospital has a patient safety evaluation system and reports data to a PSO.
- Extend Just Culture education to labor colleagues
- Focus on Ambulatory patient safety opportunities
Division of Safety and Human Development, Office of Patient Safety and Employee Safety

http://patientsafety.nychhc.org/
http://employeesafety.nychhc.org/

Thank you